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ABSTRACT

The 1997 reauthorization of the Individuals with Disabilities Education Act requires early intervention programs to serve children in natural environments. Because of geography and resources, it is often impossible for service providers to visit rural families at home as frequently as families were seen via a center-based model. At first glance, reducing visits to rural families may appear to be a serious disadvantage. However, the most efficient route to more intervention is through intervention embedded in typical daily routines and delivered by natural caregivers. In a consultation delivery model, the professional uses the intervention time to teach caregivers strategies that allow them to maximize natural learning opportunities arising in their daily activities, giving the child continuous opportunities for intervention. Transdisciplinary intervention is a flexible, holistic approach in which team members teach and learn from one another to provide integrated intervention suggestions for caregivers. Professionals can determine the frequency and team configuration for home visits based upon how often strategies will likely need modification, how much support the caregivers want or need, and what type of support is needed. One example of a team configuration might include monthly visits by therapists and weekly visits by a special educator. Although the special educator would not be qualified to prescribe therapy, the special educator can assess the child's progress and the family's comfort with strategies to determine if the therapist needs to visit more often. (TD)

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MAXIMIZING HOME VISIT TIME IS RURAL EARLY INTERVENTION

Programs for infants and toddlers with disabilities have existed since the mid-1970s, long before early intervention was added to the legislation. Many programs provided early intervention in centers or clinics exclusively for children with developmental delays and disabilities. Families brought their children to a central location to receive services. For programs providing services in rural areas, this center-based model held clear advantages for providers, not the least of which was the ability to serve as many as 10 or 15 children in a single day.

The words "natural environments" were added to early intervention legislation in the 1991 amendments to the Individuals with Disabilities Education Act (IDEA), P. L. 102-119. This language was strengthened with the 1997 reauthorization of IDEA, P.L. 105-17, requiring all early intervention programs to serve children in natural environments to the maximum extent appropriate. For many programs that provided early intervention services prior to 1997, this new emphasis meant a major shift in service delivery. Administrators of such programs faced the challenge of completely transforming their programs after the passage of IDEA 1997. Because of the semantics used in the legislation, many people have focused primarily on location, *where* the professional works with the child (Jung, in press). This shift in location posed a unique set of challenges to those serving rural populations, both in terms of logistics as well as finances.

More than a Place

Changing the location of services to homes and communities where children live is an ongoing challenge for early intervention service providers. Some rural communities are hours from the nearest early intervention program. Unlike previous years when educators and therapists could serve 15 or 20 children per day in a center, service providers now oftentimes use an entire workday to provide services to a single family. This may at first glance seem like a drastic reduction in services, especially to children and families in rural areas. However, if other dimensions of the intent of natural environments legislation are considered, children can in fact receive more intervention than is possible through a traditional, center-based program.

Merely moving the location of services from segregated to inclusive settings does not guarantee support to families (McWilliam & Strain, 1993). In fact, services that are provided in a natural location can still be delivered in an unnatural manner. For example, a speech and language pathologist may travel to an infant's home and work directly with that infant as if in a clinic while the caregiver is in another room. A physical therapist may travel to a childcare center and pull a toddler to another room to provide range-of-motion exercises. Although these locations are natural, clearly this type of service delivery ignores the purpose of the change in legislation (Turnbull, Blue-Banning, Turbiville, & Park, 1999). The following parent quote provided by Turnbull et al. (1999) illustrates explicitly how certain models of service delivery can transform the most natural environment of a child's home into a completely unnatural environment:

I readily became James' teacher. His playtime at home became 'learning time'--actually all his time was learning time. Any free time we had at home was to be spent on his therapy or to be spent feeling guilty that we weren't doing his therapy. I remember one developmental milestone he never achieved--stacking three blocks. He had finally achieved stacking two blocks; the next milestone was stacking three. I modeled for him, prompted him, and finally held his hand while we did it together. Inevitably, when left to attempt it on his own, James would pick up the blocks and throw them. He found this hysterically funny. His early intervention teacher thought he was noncompliant. James obviously didn't get the fact that his ticket to acceptance rested heavily on stacking those blocks. (p. 165)

A natural environment is much more than location (Harbin et al., 1998, NECTAS, 2000; OSEP, 2000a). The broader intent of natural environments legislation was to move beyond teaching the child to supporting families (McWilliam, 1995; McWilliam & Strain, 1993; NASDSE, 1999; OSEP, 2002). "How [services] are provided in these natural environments is just as important as where it is provided" (Hanft & Pilkington, 2000, p. 1). By

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emphasizing natural learning opportunities, consultative service delivery, and transdisciplinary teaming, early intervention service providers may be able to make the most of their short time with families.

Natural Learning Opportunities

Many service coordinators report a critical shortage of therapists willing or available to work in rural areas. Also, many service providers express concern that much of their time in serving rural populations is spent in travel. Because of the increase in travel time, many children are visited only once a week or less. Many parents as well as providers question the ability of services offered at this frequency to be as effective as services offered at higher intensities. The logical assumption is more is better. Oftentimes, the most efficient route to more intervention is not through interventionists' visits but through intervention embedded in typical daily routines and delivered by natural caregivers.

Natural learning opportunities occur throughout a child's day, whether learning is planned or unplanned (Dunst, Bruder, Trivette, & McLean, 2001). Picking vegetables in a garden, a walk in the woods, and washing dishes all provide natural learning opportunities. These activities provide many teachable moments throughout the day (Cripe & Venn, 1997; Rule, Losardo, Dinnebeil, Kaiser, & Rowland, 1998). Parents intervene in their children's development every day. They have infinitely more opportunities to enhance their child's development than a professional who visits weekly or monthly. Families do many wonderful things with their children every day to teach them without ever being told to do so by an interventionist. These daily interactions between families and children have a much greater impact on child progress than do early intervention sessions (Dunst, Bruder, Trivette, Raab, & McLean, 2001; Hanft & Pilkington, 2000; McWiliam, 2000).

Consultative Service Delivery

Consultation can be defined as a helping process in which a child receives intervention from the caregiver, who was advised by the service provider (File & Kontos, 1992). Through consultation, caregivers are given strategies that allow them to maximize natural learning opportunities or embed instruction into their daily routines and activities. Consequently, the child has opportunities for intervention all day, every day and in contexts that are meaningful to the child and family. For example, a child who is awake 12 hours per day may receive a direct intervention once per week for one hour. If no efforts are made to share strategies with the family during that hour, the child has only one hour of opportunity for this particular intervention each week. Furthermore, the one-hour of opportunity is more than likely not embedded into a natural routine. If instead that professional uses the hour to provide intervention strategies to the caregivers, the child now has 84 hours of opportunity for intervention each week. Certainly no caregiver should be consumed with thinking about providing the child with intervention 84 hours each week. However, *opportunity* for intervention can be increased using this model.

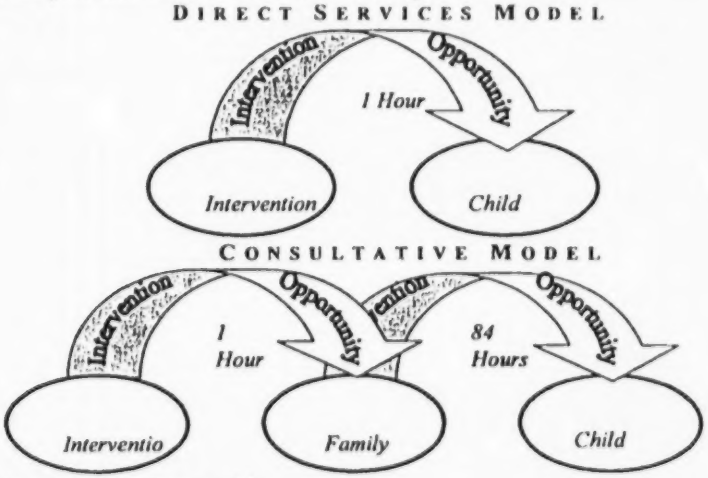

Figure 1. Weekly Intervention Opportunities

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Implications of this model are particularly exciting for families in rural environments. Using consultation, children who previously received monthly direct therapy from a therapist may now receive daily intervention from natural caregivers. By expanding the definition of intervention to include what happens when professionals are not around, families can be empowered to take back their rightful ownership of being their child's first teacher.

Some professionals argue that teaching a family strategies is not effective because parents were not trained to learn how to provide intervention (Bernheimer & Keogh, 1995). However, in the early 90s, the medical profession began to recognize the abilities of families to care for their children and began training parents on specific medical procedures necessary for the survival of children with complex health care needs. Parents mastered the ability to suction tracheotomy tubes, feed their children via gastrostomy tubes, and monitor for and respond to bradychardias and apnea (Seitz & Provence, 1990). These procedures are much more complicated than the average intervention suggested by a member of the intervention team. Furthermore, the child's life depends on the parent's ability to do these things correctly. Families in rural areas are empowered to care for their children's medical needs, though they may go for months at a time without direction from medical personnel. Certainly if parents can learn to care for tracheotomy and gastrostomy tubes without ongoing supervision they can learn developmental intervention strategies.

Transdiciplinary Teaming

Deciding frequency of visits and which professionals on the team will visit the family can be a complicated issue. Traditionally, questions like "How severe is the disability," and "Will this parent follow through" have guided how often the child is visited and by whom. At first glance, the logical course may seem to provide more services more frequently to children with delays in more areas or more severe disabilities. However, since professionals should be supporting the families' ability to function independently, visiting too often can send the wrong message. Furthermore, recent research has demonstrated that the more frequently families are visited and the greater number of professionals on the team, the less families feel supported, and child outcomes are diminished (Dunst, 1999). Transdisciplinary intervention is a flexible, holistic and dynamic approach in which team members teach and learn from one another to provide integrated intervention suggestions for parents and caregivers (Linder, 1993).

Finding a balance between enough but not too much may be difficult for professionals, especially when the financial constraint of traveling to serve rural families is added. Three questions can help guide professionals in determining frequency and team configuration for home visits: 1) How often will suggested strategies likely need to be modified, 2) How much support do the caregivers want or need to feel comfortable with the suggested strategies, and 3) What type of support is needed?

How often will strategies need to be changed?

By asking how often the strategies will need to be changed, professionals will likely arrive at a different frequency than if they had simply prescribed more visits for those with more significant disability. A child with more severe disabilities may require intervention that will not need to be changed for months at a time. For example, a child with multiple, severe disabilities may need positioning and movement strategies designed by a physical therapist. These strategies will need modifications infrequently, certainly not weekly and quite possibly not even monthly. Visiting the child each week to assess the caregivers' ability to continue with the same positioning technique is not only unnecessary, but could also be intrusive in their lives and insulting of their ability. A physical therapist attending a recent training remarked, "I go every week because the family wants me to come, but each time I pretty much say, 'good job; keep it up.'" Instead, a single member of the team could visit the family every week to ensure the family receives all supports they need. The other team members, including the physical therapist, could visit the family with the primary support person less frequently. Not only is this configuration more consistent with recommended practice, but can also alleviate a great deal of financial burden on a program attempting to provide multiple, frequent services in rural settings.

What level of support does the family need?

Instead of assuming that some caregivers will not follow through with strategies, professionals should consider what supports a caregiver will need in order to follow through. A family who has a child with cerebral palsy, for example,

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may be afraid of hurting the child as they position and stretch her. This family may need more frequent visits for a couple of weeks until they are comfortable with what they are doing.

Frequent visiting by all members of the team may also imply that the caregivers are not perceived by professionals as competent in enhancing their child's development. If interventionists focus on direct teaching activities or therapy during the visit, caregivers may infer that instruction time, divorced from their normal daily routine, is necessary for the child to learn. Too frequent visiting may lead families or childcare providers to believe that only early intervention professionals can impact development of children with delays or disabilities, which may lead to what many professionals describe as lack of follow through on the caregiver's part. If caregivers believe they have no power to increase development in their child, why would they follow through? If they feel interventionists have the power to change their child's development, of course they are gong to want them to provide direct services as frequently as possible.

What type of support is needed?

In a center-based model, programs had the luxury of providing a service for every delay for each child. For example, if a child had a delay in gross motor development, the child received service from a physical therapist. If a child had a communication delay, the child received service from a speech and language pathologist. Natural environments legislation makes this type of service delivery difficult, especially for families in rural areas. Furthermore, although this process of decision making may seem logical, there are implications for this type of decision-making. If each team member claims exclusive ownership of his or her developmental domain, a resulting team configuration may be three professionals visiting a family weekly. One family of a child with multiple severe disabilities recently remarked, "I felt like a secretary. My life was consumed with [my child's] appointments...I finally had to put an end to it. It was scary, but I just had to decide which of these specialists I needed to keep and the rest had to go. If I hadn't, I would have had a disabled child and a nervous breakdown."

Deciding who are the appropriate team members to visit most frequently is oftentimes a difficult process for teams. In developing a team configuration, one starting point can be to discuss whether the type of support needed for any given priority or concern would best be provided by a specialist (e.g., speech therapist) or a generalist (e.g., special educator). A person who is an early childhood special educator is qualified to design intervention addressing developmental delay in all five areas of development. However, intervention or therapy designed by a specialist is necessary when delays in areas such as communication, motor development, or feeding appear to be caused by a disorder, or if development in these areas is not following the typical trajectory of child development.

For example, an early childhood special educator and a speech and language pathologist may evaluate a child with a communication delay and agree that the child's delay does not appear to involve a disorder and would best be addressed by providing the caregivers with additional strategies to enhance communication. Either service provider can address this type of delay, so there is no need for both to visit. One person can then provide support and build a relationship with the family.

Had the child's communication delay been suspected by team members to be due to a disorder, the speech and language pathologist would need to have designed intervention. If the child had no other delays, only the speech and language pathologist would need to provide services. A similar approach may be used for a child with multiple and severe disabilities to avoid multiple visits each week and to maximize infrequent visits. One example of a team configuration might include monthly or bi-monthly visits by therapists and weekly visits by a special educator. Though the special educator would not be qualified to prescribe therapy for a child, the special educator can address with the family the child's progress and family's comfort with strategies to determine if the family needs a visit from any of the therapists sooner than planned.

Conclusion

The challenges of serving children in natural environments are magnified in rural areas. Because of issues surrounding geography and resources, it is oftentimes impossible for service providers to visit families as frequently as was possible through a center-based model. At first glance, a need to reduce numbers of visits to rural families may appear to be a serious disadvantage imposed by natural environments legislation. However, by examining the literature it becomes evident that increased frequency of services does not equal positive family and child outcomes;

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quite the opposite may indeed be true. By asking a few simple questions to guide decision making, teams can maximize their time in serving rural families.

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